

Prevalence and Risk Factors of Mental Disorders among Women in India: A Systematic Review

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ABSTRACT

Background: Mental disorders contribute substantially to morbidity, disability, and reduced quality of life. Women in India experience mental health risks shaped by biological transitions, comorbid health conditions, gendered social roles, violence, poverty, and limited access to timely care. This review systematically synthesizes evidence on the prevalence and associated risk factors of mental disorders among women in India.

Methods: This systematic review followed PRISMA 2020. PubMed, Epistemonikos, BASE, Google Scholar and reference lists were searched for eligible Indian studies published from January 2008 to July 2024. Two reviewers independently selected studies and extracted data. Analytical cross-sectional studies were appraised using the Joanna Briggs Institute checklist; case-control and cohort studies were assessed using the Newcastle-Ottawa Scale. Owing to substantial clinical and methodological heterogeneity, findings were synthesized narratively.

Results: Of 1,534 records identified, 114 full texts were assessed and 41 studies were included. Screening-positive depressive symptoms ranged from 5.7% to 76.8% across heterogeneous populations; postpartum depression ranged from 2.2% to 54.9%; anxiety disorders or clinically significant anxiety symptoms ranged from 0.74% to 71.3%; and common mental disorders ranged from 8.2% to 83.1%. The highest estimates arose mainly from selected clinical or highly exposed populations and should not be interpreted as population prevalence. Recurrent correlates included infertility, pregnancy and postpartum status, menopause, polycystic ovary syndrome, HIV, diabetes, socioeconomic disadvantage, limited education, widowhood, domestic or intimate partner violence, partner alcohol use, family conflict and inadequate social support. Most studies had moderate or low risk of bias, although selection bias, limited confounder control and inconsistent reporting reduced comparability.

Conclusion: Women in India experience a substantial and heterogeneous burden of mental disorders across the life course. Evidence supports a gender-responsive, community-based, and

rights-oriented mental health approach that integrates screening, counselling, violence response, and referral within reproductive, and primary healthcare services.

Keywords: Women, mental health, common mental disorders, risk factors

INTRODUCTION

Mental disorders are a major public health concern, with nearly 1.17 billion people worldwide living with a mental disorder [1]. They contribute substantially to morbidity, disability, reduced quality of life, and the overall global burden of disease [1]. In India, the burden of mental disorders is shaped by demographic transition, social adversity, gender inequality, and uneven access to mental health services [2,3]. Women constitute a major population group with distinct mental health needs because their psychological well-being is influenced by biological, reproductive, social, economic, relational, and health-system determinants [3]. Women's mental health cannot be understood only through an individual biomedical lens. Reproductive transitions, menstruation, pregnancy, childbirth, postpartum recovery, infertility, menopause, chronic illness, caregiving roles, intimate partner violence, poverty, stigma, low autonomy, and limited access to care intersect across the life course [3-5]. In the Indian context, mental health risks may be intensified by gendered household expectations, son preference, dowry-related pressure, partner alcohol use, restricted mobility, low social support, and delayed help-seeking [3,4,5]. Although Indian studies have examined depression, anxiety, postpartum depression, common mental disorders, suicidality, and psychiatric morbidity among specific groups of women, the evidence remains scattered across populations, settings, instruments, and outcomes. A systematic synthesis is therefore necessary to clarify the pattern of prevalence estimates and to organize the associated risk factors in a way that can inform public health practice, gender-responsive policy, and integrated mental health services. This review aims to synthesize evidence on the prevalence of

mental disorders among women in India and to identify biological, comorbid, and psychosocial risk factors associated with women's mental ill health.

MATERIALS & METHODS

Review design: A systematic review was undertaken and reported in accordance with PRISMA 2020 [6]. Meta-analysis was not performed because the included studies differed substantially in population, setting, sampling strategy, mental-health measure, diagnostic threshold and outcome definition. **Eligibility criteria:** Studies were eligible if they: (i) were empirical primary studies conducted in India; (ii) included women, girls, or gender-disaggregated findings for women; (iii) reported prevalence, burden, correlates, determinants, or risk factors of mental disorders or mental health symptoms; and (iv) were published in English between January 2008 and July 2024. Studies focused on adolescent girls, pregnant women, postpartum women, reproductive-age women, menopausal women, older women, women with chronic illness, women exposed to violence, and women from community or clinical settings were considered eligible. Case reports, editorials, commentaries, non-English publications, and studies without extractable women-specific mental health findings were excluded from the primary synthesis.

Sources of data and search strategy: Databases such as PubMed, Epistemonikos, BASE, and Google Scholar were searched. Search terms included combinations of "women" OR "girls" AND "mental illness" OR "mental disorders" OR "depression" OR "anxiety" OR "schizophrenia" OR "psychosis" OR "obsessive-compulsive disorder" AND "prevalence" OR "psychiatric epidemiology" AND "risk factors" OR "domestic violence" OR

“pregnancy” OR “widowhood” OR “poverty” OR “low socioeconomic status” AND “India”. Manual searches of reference lists were also undertaken to identify additional studies.

Study selection process: The search identified 1,534 records from different sources. After removing duplicates, records outside the Indian or eligible context, and non-English publications, 771 records were screened by title and abstract. Of these, 657 records were excluded because they were reviews, case reports, systematic reviews,

meta-analyses, qualitative papers without relevant prevalence data, or were not aligned with the review question. A total of 114 full-text articles were assessed for eligibility. Sixty-five articles were excluded because the population age was outside the eligibility criteria, women-specific data were not extractable, mental health outcomes were not relevant, studies were COVID-19 specific, or full text was unavailable. Forty-nine (49) studies were included in the final systematic narrative synthesis. The PRISMA flow diagram is presented in Figure 1.

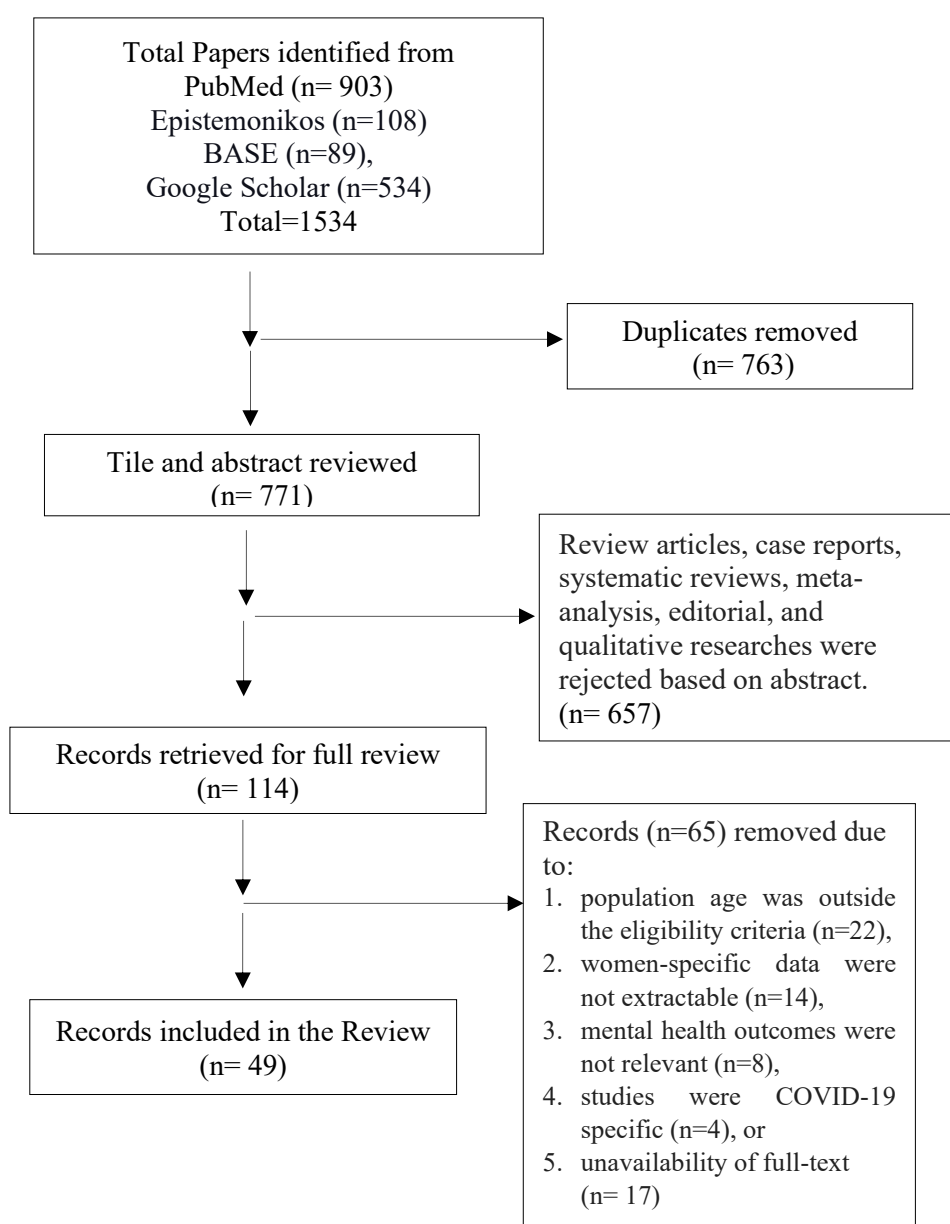


Figure 1: PRISMA diagram of the Study

Data extraction: A structured extraction sheet was used to capture author, year, location, study design, population, sample size, setting, mental health outcome, prevalence estimate, risk factors, measurement tools and key findings. Extraction was independently performed by two reviewers and cross-checked by senior reviewers. Disagreements were resolved through discussion and consensus. Data extraction was performed by four independent reviewers (RG, AC, PMB, SS) and cross-checked by AP & MW. Any discrepancies were discussed and resolved through consensus in consultation with senior reviewers (DB and AC), with all reviewers involved in the final decision-making process.

Risk-of-bias assessment: Two reviewers independently appraised each study using validated design-specific tools. Analytical cross-sectional studies were assessed with the eight-item Joanna Briggs Institute (JBI) Critical Appraisal Checklist for Analytical Cross-Sectional Studies [7]. Case-control and cohort studies were assessed with the Newcastle-Ottawa Scale (NOS) [8]. Disagreements were resolved by consensus with a senior reviewer. For classification, JBI scores of 7-8, 5-6 and 0-4 indicated low, moderate and high risk of bias, respectively; NOS scores of 7-9, 5-6 and 0-4 stars indicated low, moderate and high risk of bias.

Data synthesis: Findings were synthesised narratively in three stages. First, studies were grouped by mental health outcome, including depression, anxiety, common mental disorders, antenatal and postpartum mental health, severe mental disorders, suicidality, substance-use-related morbidity, and coping. Second, reported determinants were organised into biological and reproductive factors, comorbid health-related factors, and psychosocial determinants. Third, the evidence was interpreted using a life-course and gender-sensitive public health lens. The final synthesis was reviewed by AP, MW, DB and AC.

RESULT

Characteristics of the studies

The included studies represented diverse geographical regions, populations, and settings, including community-based surveys, hospital-based studies, national survey analyses, reproductive health settings, chronic disease contexts, and violence-related studies. Participants included adolescent girls, reproductive-age women, antenatal and postnatal women, women with infertility, menopause and postmenopausal experiences, older women, women living with HIV/AIDS, diabetes, and PCOS, as well as women exposed to domestic or intimate partner violence.

Methodological quality of included studies

Two reviewers independently assessed methodological quality using design-appropriate validated tools. Cross-sectional studies were evaluated with the eight-item JBI Critical Appraisal Checklist for Analytical Cross-Sectional Studies. Case-control and cohort studies were evaluated with the Newcastle–Ottawa Scale. Disagreements were resolved by consensus. Risk-of-bias assessment showed that 19 studies were at low risk, 20 at moderate risk and 2 at high risk of bias. Large population-based studies generally had stronger sampling and analytical methods. Item-level quality assessment is presented in [Supplementary Tables 1 and 2](#) (*Supplementary file can be accessed in the [Abstract HTML page](#). [Click here for supplementary file](#)*). Common limitations were convenience or hospital-based sampling, limited control of confounding, incomplete reporting of non-response or missing data, and reliance on screening instruments rather than diagnostic interviews.

Prevalence of Common Mental Disorders

Prevalence estimates were derived predominantly from cross-sectional studies and varied substantially by population, setting and measurement method. Screening-positive depressive symptoms ranged from 5.7% to 76.8%, postpartum depression from

2.2% to 54.9%, anxiety disorders or clinically significant anxiety symptoms from 0.74% to 71.3%, and common mental disorders from 8.2% to 83.1%. The upper estimates came from selected groups, including women receiving infertility care,

women exposed to intimate partner violence and spouses of men with alcohol dependence; they are therefore not directly comparable with community prevalence estimates. Table 1 summarises the reported prevalence of mental health outcomes.

Table 1. Prevalence of mental disorders reported in reviewed studies

Mental disorder	Prevalence range (%)	References
Depression	5.7–76.8	Bishwajit et al., 2017 ^[15] ; Hussain et al., 2015 ^[10] ; Heylen et al., 2015 ^[14] ; Indu et al., 2018 ^[27] ; Vijayalakshmi and Sunitha, 2016 ^[28] ; Jonas et al., 2014 ^[20] ; Kumar et al., 2016 ^[29] ; Nyamathi et al., 2011 ^[13] ; NMHS, 2016 ^[33] ; Powell-Jackson et al., 2016 ^[18] ; Ranasinghe et al., 2016 ^[12] ; Sinha et al., 2013 ^[21] ; Shah et al., 2017 ^[30] ; Singh and Pradhan, 2014 ^[32] ; Kamboj et al., 2023 ^[35] ; Prabhu et al., 2022 ^[40] ; Solanki and Kulkarni, 2017 ^[43] ; Sharma et al., 2019 ^[45] ; Sheeba et al., 2019 ^[46] ; Kamimura et al., 2017 ^[25] ; Hudge et al., 2022 ^[47]
Postpartum depression	2.2–54.9	Shivalli and Gururaj, 2015 ^[17] ; Singh et al., 2023 ^[34] ; Dubey et al., 2012 ^[41] ; Fatima et al., 2024 ^[42] ; Dadhwal et al., 2023 ^[44]
Neurotic and stress-related disorders	4.50	NMHS, 2016 ^[33]
Anxiety disorders or clinically significant anxiety symptoms	0.74–71.3	Christian et al., 2012 ^[31] ; Madhavanprabhakaran et al., 2015 ^[26] ; NIMHANS, 2016 ^[33] ; Ranasinghe et al., 2016 ^[12] ; Weaver and Madhu, 2015 ^[11]
Common mental disorders	8.2–83.1	Soni et al., 2016 ^[9] ; Hussain et al., 2015 ^[10] ; Chandra et al., 2009 ^[23] ; Kumar et al., 2016 ^[29] ; Shidhaye and Patel, 2010 ^[22] ; Fahey et al., 2016 ^[16] ; Nayak et al., 2010 ^[24] ; Kamboj et al., 2023 ^[35] ; Sathe et al., 2024 ^[37] ; Dadhwal et al., 2022 ^[39] ; Hudge et al., 2022 ^[47] ; Basu et al., 2024 ^[48]

This variation reflects differences in study settings, population characteristics, use of instrument to capture mental health outcomes, and sampling methods. Depression and anxiety were repeatedly reported among women experiencing reproductive transitions, chronic illness, partner violence, low socioeconomic status and inadequate social support.

Severe mental disorders, substance use and suicidality

Severe mental disorders were reported less frequently than common mental disorders. Evidence from national and clinical studies documented schizophrenia, bipolar affective disorder, suicidality and severe psychiatric morbidity among women, although gender

differences were not uniform across conditions [10,33,55]. Women with severe mental illness may also experience abandonment, homelessness, sexual abuse and barriers to rehabilitation [5]. Substance-use-related morbidity among women was less frequently reported, potentially reflecting stigma and under-disclosure. The available studies documented alcohol or tobacco use and the mental-health consequences of a partner's alcohol dependence in relation to depression, anxiety, violence and suicidality [20,24,27,28,30,47]. Suicidality was particularly concerning among women exposed to violence, reproductive complications or severe psychological distress [10,20,27,28,47,55].

Table 2. Prevalence and associated risk factors for mental disorders among women in India

Sl. No.	Location of the study	Methodology	Prevalence	Associated risk factors	Authors and year
1	Gujarat, India	Cross-sectional study	Potential CMD (SRQ-20): 22.8%	Poor self-rated health, disability, adverse healthcare and financial indicators; substantial non-recognition	Soni, et al,2016 [9]
2	Kashmir, India	Case-control study 110 patients.	• Depressive disorder 23%, • Dysthymia: 1.8%, • Panic disorder: 15.45%, • OCD: 6.36%, • Suicidality: 8%, • Bipolar affective disorder: 2.72%, • GAD: 15.45%.	• PCOS	Hussain et al., 2015 [10]
3	New Delhi, India	Exploratory study 184 diabetic women	• Anxiety: 26.6% • Depression: 19%	• Not reported	Weaver &Madhu, 2015 [11]
4	India and 11 other countries	Cross-sectional 7904womenfrom India	• Depression: 25.5% • Insomnia: 7.8% • Anxiety: 8.6%	• Poor hygiene • Elevated infections	Ranasinghe et al., 2016 [12]
5	Andhra Pradesh, India	Cross-sectional study 68 rural women living with HIV	• Depression :54.4%	• Stigma	Nyamathi et al., 2011 [13]
6	Karnataka, India	Secondary data analyses. 372 women	No prevalence reported; adjusted association with poorer psychological well-being (exp[B] = 2.26, p = 0.004)	• Food insecurity and internalized stigma	Heylen et al., 2015 [14]
7	India	Cross-sectional study 1077 men and 1047 women, ages 50 and above	Self- reported depression: 40.3% Diagnosed with depression: 17.7%	• Marriage • No formal education • Not engaging in any type of physical activity	Bishwajit et al., 2017 [15]
8	Gujarat, India	Cross-sectional survey 700 rural women	Common mental disorders: 23.7%	• Gender • Reproductive age	Fahey et al., 2016 [16]
9	Karnataka, India	Hospital based analytical cross-sectional study.	Post-natal depression: (31.4%)	• Birth of female child • Poverty	Shivalli &Gururaj, 2015 [17]

		Postnatal follow-up of 102 women from 4 th -10 th week.		• Complication during pregnancy	
10	Uttar Pradesh, India	Cross-sectional 1695 women 15-49 years of age	Treatment group: • Severe depression = 1%, • Moderate depression = 20%. Comparison group: • Severe depression = 3%, • Moderate depression = 29%.	• JSY is negatively related to depression.	Powell-Jackson et al., 2016 [18]
11	New Delhi, India	Community Survey 195 subjects	• Possible depression: 59.4% • Suicidal thoughts: 10.9% Found positive for likely depression: 36.6%	• Low socioeconomic status	Nagpal et al., 2008 [19]
12	Maharashtra, India	Population-based cross-sectional study 4711 tribal belt subjects, ages 30 and above	• Mild to moderate depression: 33.5% of men, 44.8% of women • Major depression: 8.1% of men, 17.3% of women	• Not reported	Jonas et al., 2014 [20]
13	Tamil Nadu, India	Cross-sectional descriptive study 103 respondents, 60-69 years of age	• Depression: 60% women; men 29.3%.	• Widowhood • Chronic disease and disability • Pain • Limitations in activities of daily living • Personality traits (dependent, anxious or avoidant) • Adverse life events (separation, divorce, bereavement, poverty, social isolation) • Lack of adequate social support.	Sinha et al., 2013 [21]
14	Bihar, Jharkhand, Maharashtra, Tamil Nadu, India	NFHS 2 & Follow up Survey • 5703 rural women, • Age 15-39 years	• CMD : 10.7%	• Age-group of 15-39 • Low-socioeconomic • Gender disadvantage	Shidhaye & Patel, 2010 [22]
15	India	Cross-sectional Study	• Depression: 31%	• Reported IPV = 56%	Chandra et al., 2009 [23]

		• 105 women, • Age 18-49 years	• Anxiety disorder: 3% • Minor psychiatric disorders: 11%		
16	Goa, India	Cross-sectional • 821 women, • 18-49 years of age	• CMD: 8.2%	• Excessive alcohol use by partner • Partner violence • Increasing age • Low education • Lack of paid employment	Nayak et al., 2010 [24]
17	Gujarat, India	Cross-sectional study. 219 women, ages 18-62 years of age	• Reported IPV: 50% of the ever-married women faced IPV.	• Multiple types of violence	Kamimura et al., 2017 [25]
18	Kerala, India	Prospective explorative survey • 500 low-risk pregnant women • Age 18-35	• Prevalence of pregnancy-specific anxiety during the third trimester of pregnancy - Moderate: 71% - Severe: 29%	• Young age, • Nuclear family nature	Madhavanprabhakaran, D'Souza & Nairy, 2015 [26]
19	Kerala, India	A cross-sectional study	• Depression:25.0% • Anxiety disorders: 10% • Adjustment disorders: 53%	• Alcohol-dependent males • Marriage • Stressful life events	Indu et al., 2018 [27]
20	Tamilnadu, India	Cross-sectional study	• Suicidal thoughts: 11% • Severe depression: 35%	• Alcohol-dependent males • Intimate partner violence	Vijayalakshmi, 2016 [28]
21	Mysore, India	Cross-sectional study conducted in the tertiary maternity care hospital. • 152 participants within 2 weeks after delivery • Age 18 to 35 years	• CMD: 44% • Depression: 26% • Obsession of child harm: 8.55% • Social phobia: 5.92	• Number of previous stillbirths dead children before this delivery	Kumar et al., 2016 [29]
22	Maharashtra, India	Cross-sectional controlled study • 100 cases	• Depression: 36% • Anxiety: 16% • Stress disorder: 6%	• Domestic violence • Marital conflicts • Marital rape and assault	Shah et al., 2017 [30]
23	Vadodara, India	Cross-sectional study • 147 post-menopausal women	• Insomnia:57.1% • Anxiety:38.1% • Lack of concentration:33.3%	• Not reported	Christian, Kathad, & Bhavsar, 2012 [31]
24	New Delhi, India	Cross-sectional study • 252 post-menopausal women	• Depression:32.1% • Anxiety:21.0%	• Not reported	Singh, & Pradhan, 2014 [32]

		• Age 40-54 years			
25	12 states of the country	Household survey in 12 states across 6 regions of India • 10610 household contacted • 34802 individuals interviewed	Common mental disorders: Women: 9.57; Men: 15.22 Severe mental disorders: Women: 1.73; Men: 2.15 Schizophrenia: Women: 1. Men: 1.49; Neurotic and stress-related disorder: Women: 4.5; Men: 2.85 Generalized anxiety disorder: Women: 2.34; Men: 1.46	• Not reported	NMHS, 2016 [33]
26	Nagaland, India	Hospital-based prospective study; 162 women completing follow-up; EPDS	Postpartum depression screen positive: 54.94% initially; 18.52% at 2-4 weeks	History of miscarriage (p = 0.042)	Singh et al., 2023 [34]
27	New Delhi, India	Hospital based • Pretested modified interview schedule- demographic variables, lifestyle variables, and reproductive trajectories, PSS, GAD-7, and PHQ-9 • 500 women (250 infertile/250 fertile)	• Stress (Medium+ Normal): 86.8%, Anxiety: 43.6%, Depression: 76.8%; women High Stress (Severe) -22.8%	• Husband's employment type • Infrequent intercourse during the fertile window • Infertility duration-for over 5 years • Disturbed menstruation • Family structure	Kamboj et al, 2023 [35]
28	Mumbai, Maharashtra, India	• Hospital-based prospective observational study	• 38.6%- Anxiety • 25.7%- Depression	• PCOS Infertility and alopecia were associated with anxiety, while acne was associated with depression.	Chaudhari, Mazumdar, & Mehta, 2018 [36]
29	Central India	Community-based cross-sectional, observational descriptive study	• 68.8%- Depression • 71.3%- Anxiety • 17.5%- PTSD	• Intimate partner violence (Physical violence, emotional abuse, sexual abuse)	Sathe et al., 2024 [37]
30	Delhi, India	Quantitative interview with non-probability consecutive sampling method • WHO-5 perceived well-being scale	Poor psychological well-being: 54.8% among infertile women and 15.2% among fertile women	• Infertility • Primary infertility had substantially higher poor psychological well-being with an odds ratio of 6.76.	Sharma et. al, 2022 [38]

		500 women (250 fertile & 250 infertile)			
31	Tertiary care hospital in Northern India	Cross-sectional hospital-based study with 150 interviews with infertile women in Hindi - Purposive sampling - Hamilton Depression Rating Scale (HDRS) - Hamilton Anxiety Rating Scale (HAM-A), - WHO-Quality of Life-BREF (WHOQOL)- Hindi, - The Rosenberg Self-Esteem Scale (RSES), - Brief-COPE Inventory (COPE)	58% with depression, 24% with anxiety, 24% with both	- Infertility - Family structure - Financial stress - Social discrimination - Maladaptive coping strategies	Dadhwal et al., 2022 [39]
32	Tertiary care hospital, South India	Cross-sectional hospital-based - Consecutive sampling method 314 pregnant women - Edinburgh Postnatal Depression Scale (EPDS)	21.98% - Antenatal Depression	- Young age (AOR = 2.01; 95% CI: 0.56–7.20) - Lower education (AOR = 1.52), - Homemakers (AOR = 1.37), - First-time pregnant women (primigravida) (AOR = 1.13), - History of miscarriage (AOR = 1.56)	Prabhu et. al, 2022 [40]
33	New Delhi, India	Cross-sectional, hospital-based - Consecutive sampling 506 peripartum women EPDS (Hindi version)	6% - Postpartum Depression	- Marital discord (2%), - Nuclear family (p = 0.019) - Birth of female child (strong risk factor- (p = 0.00001)	Dubey et. al., 2012 [41]
34	Jharkhand, Tata Main Hospital	Prospective observational study 174 women - Edinburgh Postnatal Depression Scale (EPDS) & GHQ-12	Postpartum depression: 14.28%	- Low socioeconomic class - One or more perinatal losses - Female babies	Fatima et al., 2024 [42]
35	Mumbai, India	Cross-sectional comparative community-based survey Systematic random sampling	Depressive symptoms: 54.3%	- Lower socioeconomic status, - Lower educational qualification,	Solanki & Kulkarni, 2017 [43]

		• 254 women • Centre for Epidemiological Studies Depression Scale, 20-item version (CES-D-20)		• Adverse marital status (being widowed, divorced, or separated), • Presence of somatic/psychosomatic complaint • Substance use	
36	Delhi, India	Community-based cross-sectional study • 680 postpartum women • EPDS for postpartum depression • STAI for postpartum anxiety. • Screen-positive women were diagnostically assessed using MINI.	Any postpartum depression/anxiety: 5.6%; depression: 2.2%; anxiety: 0.74%; comorbidity: 2.8%	• Maternal & spouse illiteracy • Lower socioeconomic status • Family history of substance use • Higher parenting stress • Poor recent lifestyle • Lower partner and family support • Lower marital satisfaction • Higher intimate partner violence	Dadhwal et al., 2023 [44]
37	Urban and rural Delhi, India	Cross-sectional study using mixed methods • Cluster and systematic random sampling- 827 • WHO questionnaire on DV, Self-Reporting Questionnaire-20 (SRQ-20)	25%- Depression	• Domestic Violence	Sharma et al., 2019 [45]
38	Bangalore, India	Hospital-based cross-sectional prevalence study • Pregnant women attending antenatal clinic-280 (Pregnant women <6 months gestation) • EPDS, MSPSS, PRAQ	• 36%- Prenatal/Antenatal Depression	• Domestic violence • Pregnancy-related anxiety • Marital Discord	Sheeba et al., 2019 [46]
39	Mangalore, Karnataka, India	Cross-sectional study • Non-probability purposive sampling • 65 spouses/partners of men with Alcohol Dependence Syndrome	• 83.1% - Common mental disorders • 52.3% - Depression • 30.8% - Suicidality	• Emotional violence • Husband's irregular employment, • Husband's alcohol severity	Hudge et al., 2022 [47]

		Tools used: Socio-demographic data sheet, AUDIT, SRQ-20, MINI-PLUS, and Demographic and Health Survey Tool– Domestic Violence Module.	27.7% - Dysthymia 4.6% - Panic disorder 1.5% - PTSD 84.6%- Intimate partner violence		
40	India The study used nationally representative data from the Longitudinal Ageing Study in India (LASI), Wave 1.	Secondary data analysis of LASI Wave 1. - Population: postmenopausal women aged ≥ 50 years. - Depression was assessed using the Centre for Epidemiological Studies Depression Scale (CES-D)	21.76%- Depression among women aged ≥ 50 years 17.60%- Depression among women aged < 50 years	- Menopause - Rural residence - Multimorbidity / chronic health conditions.	Basu et al., 2024 [48]
41	North Karnataka, South India	Cross-sectional study; 13–14-year-old adolescent girls	Psychological distress	Poverty / low socioeconomic status, gender inequity, and lack of school safety.	Beattie et al., 2019 [49]
42	Bengaluru City, India	Screening study at a government maternity hospital; pregnant women availing antenatal care	Antepartum anxiety and depression	Low family income, lack of spousal support, and a history of previous pregnancy complications or losses.	Johnson et al., 2018 [50]
43	Southern Rajasthan, India	Prospective cohort study; 1,542 rural women followed through their first postpartum year	Psychological distress, decreased quality of life, and compromised physical functioning.	Experience of severe or less-severe maternal/obstetric complications at childbirth or during the immediate postpartum period.	Iyengar et al., 2012 [51]
44	North region, India	Clinical study comparing postpartum women against non-pregnant peers	Significantly higher cognitive deficits (memory and concentration issues), elevated depression, and anxiety.	Biological/hormonal fluctuations during childbirth combined with the stress of adapting to the maternal role.	Meena et al., 2016 [52]
45	Bangalore, Southern India	Hospital-based cohort study; pregnant women at less than 24 weeks of gestation	Early pregnancy-related anxiety	Lack of social support, lower household income, unplanned pregnancy, and a history of previous pregnancy losses.	Nath et al., 2019 [53]

46	Odisha, India	Systematic data collection study across slums, rural, and tribal villages evaluating different reproductive life stages	• High levels of chronic environmental stress and fear (Sanitation-Related Psychosocial Stress - SRPS).	• Inadequate access to clean/private water and sanitation resources; highest stress tied to managing menstruation and open defecation routines.	Hulland et al., 2015 [54]
48	Sundarban, West Bengal, India	Clinical epidemiological record analysis of 1,277 patients admitted to six island hospitals	• Deliberate self-harm (DSH) and suicide attempts; women accounted for 65.2% of DSH admissions and 67.1% of recorded deaths.	• Acute marital conflict, domestic discord, low socioeconomic resilience, and easy household accessibility of highly toxic chemical pesticides.	Banerjee et al., 2009 [55]
49	Kolkata	Community-based cross-sectional study among ever-married women aged 15–45 years in an urban slum	• Domestic violence: 54%; 41.9% experienced current and lifetime physical or psychological abuse	• Husband's alcohol dependence and multiple sexual partners; property ownership, higher income and social support were protective	Sinha et al., 2012 [56]

Abbreviations: CMD, common mental disorders; CES-D, Center for Epidemiologic Studies Depression Scale; EPDS, Edinburgh Postnatal Depression Scale; GAD, generalized anxiety disorder; GHQ, General Health Questionnaire; HAM-A, Hamilton Anxiety Rating Scale; HDRS, Hamilton Depression Rating Scale; IPV, intimate partner violence; MINI, Mini International Neuropsychiatric Interview; MSPSS, Multidimensional Scale of Perceived Social Support; OCD, obsessive-compulsive disorder; PCOS, polycystic ovary syndrome; PRAQ, Pregnancy-Related Anxiety Questionnaire; PSS, Perceived Stress Scale; PTSD, post-traumatic stress disorder; RSES, Rosenberg Self-Esteem Scale; SRQ-20, Self-Reporting Questionnaire-20; STAI, State-Trait Anxiety Inventory; WHOQOL-BREF, World Health Organization Quality of Life-BREF.

Associated Risk Factors

Authors identified factors reported as determinants of women's mental health. Table 2 presents studies that reported prevalence and associated risk factors, whereas Table 3 highlights various risk factors associated with reported mental health outcomes. Major associated risk factors reported in these studies were categorised into 1) biological & reproductive risk factors, 2) comorbid conditions and 3) socio-economic & environmental factors and social norms & gender-based violence.

Biological and reproductive risk factors:

Women's vulnerability to mental-health problems varies across the reproductive life course. Puberty and menstruation may be accompanied by psychological distress, depressive symptoms and anxiety, particularly when biological changes coincide with school discontinuation, restricted mobility, early marriage or gender-based expectations [49,54]. Pregnancy is associated with antenatal depression, pregnancy-specific anxiety and common mental disorders, while younger maternal age, primigravida status, previous miscarriage, marital discord, inadequate social support and socioeconomic disadvantage may increase vulnerability [26,40,46,50,53]. During the postpartum period, women may experience depression, anxiety, suicidal ideation, cognitive difficulties and impaired psychological well-being; reported correlates include delivery complications, perinatal loss, low income, limited family support, marital dissatisfaction and the birth of a female child in settings characterised by son preference [17-19,29,34,41,42,44,51,52]. Infertility is associated with depression, anxiety, stress, poor psychological well-being, reduced self-esteem and maladaptive coping, particularly when accompanied by prolonged treatment, financial strain, marital pressure and social discrimination [35,38,39]. Menopause and postmenopausal transition are associated with depression, anxiety, sleep disturbance, somatic symptoms, impaired concentration and reduced quality of life [31,32,48].

Comorbid health conditions: Physical and reproductive health conditions may contribute to mental-health vulnerability through symptom burden, functional limitation, uncertainty about prognosis, stigma and reduced quality of life. Women with diabetes have reported anxiety and depressive symptoms [11], whereas women living with HIV/AIDS have experienced depression, psychological distress and diminished psychological well-being, often intensified by food insecurity and internalised stigma [13,14]. Polycystic ovary syndrome has been associated with depression, generalised anxiety disorder, panic disorder, obsessive-compulsive symptoms and bipolar affective disorder; infertility, acne and alopecia may further compound psychological distress among affected women [10,36]. Chronic illness, multimorbidity, disability, persistent pain, somatic complaints and sleep disturbance are also associated with depression, anxiety, common mental disorders, functional impairment and reduced quality of life [9,21,43,48].

Socioeconomic and environmental factors:

Poverty, unemployment or lack of paid work, and adverse living conditions are associated with depression, anxiety, psychological distress and common mental disorders [9,15-18,22,24,43]. Food insecurity may generate persistent uncertainty and household stress [14] while inadequate sanitation are associated with fear, shame, safety concerns and daily psychosocial strain [54].

Social norms and gender-based violence:

Women's mental health is socially patterned. Violence and adverse relational environments constitute particularly consistent determinants of women's adverse mental health outcomes. Domestic and intimate partner violence—including physical, emotional and sexual violence—are associated with depression, anxiety, post-traumatic stress symptoms, common mental disorders, psychological morbidity, suicidal

ideation and reduced quality of life [23-25,27,28,30,37,45-47,55,56]. Childhood abuse, abuse by in-laws, marital rape, assault and dowry-related harassment may produce cumulative psychological consequences across the life course [25]. A partner's harmful alcohol use may increase women's exposure to violence, economic insecurity and marital conflict and is associated with depression, anxiety, suicidality and broader psychiatric morbidity [24,27,30,47]. Widowhood, separation and other adverse marital circumstances are associated with depressive symptoms, psychological distress, and poorer health outcomes [21,43]. Low autonomy may further restrict women's

control over mobility, healthcare use, employment, household resources and reproductive decisions, thereby increasing vulnerability to common mental disorders [22,24]. Lack of social support, restrictive family relationships, caregiving pressure and gender discrimination may further intensify distress, particularly during pregnancy, postpartum recovery and infertility [35,39,40,44,46,50,53]. Stigma can worsen psychological wellbeing, discourage disclosure and delay help-seeking, especially among women living with HIV/AIDS, infertility or severe mental illness [13,14,38].

Table 3. Risk factors and associated mental health outcomes among women

Risk-factor domain	Risk factors	Associated mental-health outcomes
Biological and reproductive factors	Puberty	Psychological distress; depressive symptoms; anxiety symptoms
	Menstruation and menstrual difficulties	Depression; anxiety; psychological distress; impaired emotional well-being
	Pregnancy	Antenatal depression; pregnancy-related anxiety; common mental disorders
	Postpartum period	Postpartum depression; anxiety; psychological distress; suicidal ideation
	Infertility	Depression; anxiety; stress; reduced psychological well-being
	Menopause	Depression; anxiety; sleep disturbance; psychological distress
	Birth of a female child (in settings where male-child preference is prominent)	Postpartum depressive symptoms; psychological distress
Comorbid health conditions	Diabetes	Depression; anxiety symptoms; diabetes-related emotional distress
	HIV/AIDS	Depression; anxiety; psychological distress; reduced psychological well-being
	Polycystic ovary syndrome (PCOS)	Depression; generalized anxiety disorder; panic disorder; obsessive-compulsive symptoms; bipolar disorder
	Endometriosis	Depression; anxiety; psychological distress; reduced quality of life
	Chronic illness	Depression; anxiety; common mental disorders; psychological distress
	Pain disorders	Depression; anxiety; sleep disturbance; functional impairment
	Sleep disorders	Depression; anxiety; psychological distress; reduced well-being
Socioeconomic and environmental factors	Low educational attainment	Depression; anxiety; common mental disorders; antenatal or postpartum depression
	Poverty and socioeconomic disadvantage	Depression; anxiety; psychological distress; common mental disorders
	Food insecurity	Depression; stress; anxiety; reduced psychological well-being
	Poor sanitation	Stress; anxiety; psychological distress

	Unemployment or lack of paid work	Depression; common mental disorders; reduced psychological well-being
Social norms, and Gender-based violence	Domestic or intimate partner violence	Depression; anxiety; post-traumatic stress symptoms; common mental disorders; suicidal ideation
	Marital conflict	Depression; anxiety; adjustment difficulties; postpartum depression
	Partner alcohol use	Depression; anxiety; common mental disorders; suicidal ideation
	Gender discrimination	Depression; psychological distress; anxiety; self-harm risk
	Widowhood or adverse marital status	Depression; psychological distress; social isolation
	Social isolation	Depression; anxiety; common mental disorders; reduced psychological well-being
	Low autonomy	Depression; anxiety; psychological distress; common mental disorders
	Lack of social support	Antenatal or postpartum depression; anxiety; common mental disorders
	Family pressure and restrictive family dynamics	Depression; anxiety; psychological distress
	Mental health-related stigma	Depression; reduced psychological well-being; delayed help-seeking and treatment uptake

Coping and social support

Evidence on coping was limited but important. Women experiencing infertility and family stress reported maladaptive coping patterns such as denial and behavioural disengagement [39]. Local social support, family support, and supportive household environments appeared to reduce vulnerability, while social isolation, low autonomy, stigma, and family conflict intensified distress.

DISCUSSION

This review found a substantial but heterogeneous burden of mental-health symptoms and disorders among women in India. Variation reflected differences in sampling frames, life stage, exposure profile, research instruments and varying thresholds across instruments. Population-based estimates were generally lower than estimates from selected clinical or violence-exposed groups. Accordingly, the reported ranges should be interpreted as a description of the evidence base rather than as a pooled national prevalence. The findings indicate that reproductive transitions, chronic conditions and social adversity frequently co-occur, supporting a life-course and

gender-responsive interpretation of women's mental health [5].

Biological transitions were embedded within social expectations concerning marriage, fertility, motherhood, caregiving and family roles. Infertility, pregnancy, postpartum recovery and menopause were associated with distress, but their effects were often conditioned by poverty, stigma, constrained autonomy, family conflict, violence and limited support [18,23-27,36-39,41-50]. These cross-sectional associations do not establish causality. A life-course approach is warranted. Evidence among adolescent girls linked psychological distress with social vulnerability and violence, while studies of reproductive-age and older women demonstrated changing risks related to fertility, maternity, chronic illness, menopause, widowhood and functional limitations [12,13,24,42-50].

Pregnancy and the postpartum period emerged as important stages of psychological vulnerability. Women experiencing poverty, pregnancy loss, marital difficulties, limited family support or intimate partner violence appeared particularly susceptible to antenatal and postpartum depression and anxiety. Maternal

healthcare should therefore recognise the influence of family and social circumstances while protecting women's autonomy, safety and confidentiality [3,5,58]. Antenatal and postnatal services provide practical opportunities for validated mental-health screening, suicide-risk assessment, initial psychosocial support and referral when specialised care is required [58].

Infertility was also associated with stress, anxiety, depressive symptoms, poor psychological well-being and unhelpful coping responses. Fertility services should recognise this emotional burden and offer couple counselling without implying that responsibility for infertility rests primarily with women. Those experiencing clinically significant distress should be referred for appropriate mental-health care [5]. Evidence relating to menopause and post-menopause was more limited, but women reported depression, anxiety, insomnia, difficulty concentrating and poorer quality of life [5,57,59]. The mental-health needs of women in midlife should therefore receive greater attention within primary care, non-communicable disease services and healthy-ageing programmes.

Women living with diabetes, HIV, polycystic ovary syndrome and other chronic or reproductive conditions frequently experienced anxiety, depression and broader psychological distress. These findings illustrate how physical symptoms, treatment demands, stigma and uncertainty can affect emotional well-being. Mental and physical healthcare should therefore be integrated instead of being delivered through disconnected services [2,5]. Screening can support early recognition, but it will have limited value unless positive findings are followed by appropriate assessment, counselling, referral and affordable care.

Women's mental health was also shaped by their social and economic circumstances. Financial hardship, limited education, food insecurity, widowhood, a partner's harmful alcohol use, inadequate social support and restrictive gender norms appeared repeatedly across the evidence base [5]. Violence was

especially important and was associated with depression, anxiety, post-traumatic stress symptoms and suicidality [3,5,60]. Mental-health services should therefore be connected with confidential enquiry about violence, safety planning, social protection and appropriate legal and violence-response services [3]. The influence of family structure was not uniform. Joint families could provide practical and emotional support, but they could also expose women to greater conflict or pressure related to marriage and childbearing. Nuclear families might offer greater privacy and autonomy while leaving women with less day-to-day support. The findings suggest that the quality, safety and responsiveness of family relationships are more important for women's mental health than household structure alone [5].

Implications of findings

The findings support integrating women's mental-health screening and first-line support into primary care, reproductive and child health, adolescent health, fertility, HIV and NCD care services. Implementation requires standardized screening tools, trained providers, privacy, clear referral mechanism, availability of essential psychotropic medicines, follow-up and monitoring of patient outcomes [2,4,5,58]. Care should be gender-responsive and rights-based, recognizing women as individuals rather than defining their distress primarily through reproductive or family roles.

Guided by the WHO Commission on Social Determinants of Health framework, action should extend beyond healthcare to address the structural and intermediary conditions shaping women's mental health, including limited autonomy, power, discriminatory gender norms, poverty, limited education and employment, food insecurity, inadequate sanitation, reproductive pressure, unpaid caregiving, social isolation and violence. Coordinated interventions across individual, family, community, health-system and policy levels should combine psychosocial support with social protection, livelihood opportunities, reproductive autonomy, safe

workplaces and violence prevention. As outlined in Table 4, these multipronged strategies should be evaluated for clinical effectiveness, safety, equity, and their capacity to reduce inequalities across the life course.

Addressing the social determinants of women's mental health requires coordinated action across policy, health-system, community and family levels. Structural inequalities should be addressed through effective legislation, social protection, gender-responsive budgeting and intersectoral collaboration. A life-course approach is required to respond to women's changing needs during adolescence, reproductive age, pregnancy, postpartum recovery, infertility, menopause, widowhood and older age. Mental-health screening, first-line psychosocial support, treatment and referral should be integrated into primary

care, reproductive and maternal health, fertility, HIV, diabetes, NCD and geriatric services. These measures should be accompanied by prevention of domestic, sexual and intimate partner violence and confidential, survivor-centred responses that include safety assessment, trauma-informed counselling, legal assistance, shelter and referral. Family and community interventions should strengthen supportive relationships, women's groups, peer networks and mental-health awareness while reducing stigma, harmful gender norms and unequal caregiving burdens. Following the principle of proportionate universalism, essential mental-health services should be available to all women, with progressively greater outreach, resources and support for those experiencing greater social and economic disadvantage.

Table 4. Proposed multipronged strategic actions to for coordinated mental health actions

Strategic domain	Immediate actions	Short-term actions	Long-term actions
Structural and policy action	• Map existing policies related to mental health, gender-based violence, education, employment, social protection, food security, sanitation, housing, reproductive health in the state; • Establish an intersectoral women's mental-health task force; • Identify gaps in existing schemes and legal provisions for protection.	• Strengthen implementation of protections against domestic violence, sexual violence, dowry harassment, and child marriage; • Expand access to financial inclusion, livelihood programmes, and social-protection entitlements; • Initiate gender-responsive budgeting, introduce gender-equity impact assessment.	• Institutionalise a Health-in-All-Policies approach; reduce structural gender inequalities in education, employment, and income; • Establish sustained gender-responsive financing; • Strengthen convergence & coordination among health, women and child development, social justice, law enforcement and judicial systems.
Life-course prevention	• Identify age- and life-stage-specific risks; introduce menstrual-health education, life skills and confidential counselling in selected schools; • Include basic mental-health assessment in antenatal, postnatal, infertility, menopause and geriatric services; • Train providers in age-appropriate and gender-responsive care.	• Scale school and college mental-health programmes; integrate reproductive autonomy, contraception, infertility counselling and violence prevention into reproductive-health services; • Implement repeated antenatal and postnatal screening; • Develop menopause and healthy-ageing mental-health screening	• Establish a universal life-course women's mental-health programme spanning adolescence, reproductive age, pregnancy, postpartum, menopause and older age; • Link health interventions with education, social protection, employment and community participation throughout the life course.
Integrated healthcare delivery	• Introduce brief, validated screening in selected Ayushman Arogya Mandirs, PHCs and maternal-health services; • Develop standard operating procedures for assessment, psychosocial first aid, lay counselling, referral and follow-up; • Map available mental-health and social services; • Ensure private and confidential consultation spaces.	• Expand stepped mental-health care across primary care, sexual and reproductive health, NCD, and geriatric services. • Strengthen referral coordination with the District Mental Health Programme and Tele-MANAS. • Ensure the availability of essential psychotropic medicines. • Introduce referral tracking, supportive supervision and periodic quality audits.	• Integrate women's mental health comprehensively across primary and specialist healthcare. • Establish interoperable referral and follow-up systems. • Institutionalise collaborative care. • Develop sustainable quality-assurance mechanisms.
Addressing gender-based violence	• Ensure private and confidential enquiry about violence; train providers in survivor-centred and trauma-informed care; introduce	• Establish formal referral protocols between health facilities, violence-response services, legal aid, police, shelters, social welfare and de-addiction services;	• Institutionalise an integrated violence and mental-health response across health, legal and social-protection systems;

	immediate safety and suicide-risk assessment; • Prepare communication materials for One Stop Centres, protection officers, shelters, legal aid, police and financial support; • Prohibit disclosure to partners or families without consent.	• Strengthen coordination, counselling, crisis support and follow-up; • Create safe documentation and data-protection procedures	• Strengthen prevention through gender-transformative programmes and alcohol-harm reduction; • Ensure sustained access to shelter, legal protection, economic rehabilitation and long-term trauma care.
Family and community interventions	• Map community resources; establish women-led peer-support groups in priority areas; orient ASHAs, Anganwadi workers and community leaders to identify distress and facilitate referral; • Initiate mental-health literacy and anti-stigma communication; assess relational safety before involving family members.	• Expand peer-support networks and caregiver-support programmes; • Engage men and boys in gender equality, shared caregiving and non-violence; • Involve self-help groups, schools and Panchayati Raj Institutions with Village/Taluka/District Mental Health Programme; • Develop community responses to harmful alcohol use; • Establish referral links between community platforms/social resources and primary care.	• Sustain community-based mental-health promotion through local governance and women's collectives; • Strengthen equitable gender norms, shared caregiving and collective agency; • Institutionalise community participation and lived-experience leadership in programme planning and evaluation.
Proportionate universalism and Equity-oriented monitoring	• Identify and provision additional outreach and support to women experiencing violence, poverty, disability, infertility, pregnancy loss, HIV, chronic illness, etc.; • Map geographic and social gaps in service coverage; define a minimum equity-indicators; • Gather disaggregated data; • Establish baseline measures for access, affordability, quality and outcomes; • Involve women with lived experience in planning, implementation & evaluation; introduce priority outreach and facilitated referrals	• Expand mobile, community-based and tele-mental-health services in underserved areas; provide transport, childcare and financial assistance; allocate health & wellness counsellor at PHC, develop tailored interventions for women with disabilities, migrants and other underrepresented groups; • Develop & integrate equity indicators into HMIS and programme reviews; monitor the care pathways from screening to treatment, recovery, and rehabilitation; • Measure patient-reported experience & outcomes; conduct district equity audits; report gaps and take corrective actions.	• Embed equity-focused planning, financing and evaluating within district and state health systems; reduce avoidable social and geographic inequalities in outcomes; • establish longitudinal surveillance of women's mental health and its social determinants; evaluate policy and programme effects on absolute and relative inequities; promote implementation & policy research, and document notable practices.

Strengths and limitations of the study

This review synthesised evidence across life stages, clinical conditions and social contexts. The review highlights women's mental health outcomes and associated risk factors. However, limitations of the review should be acknowledged. The evidence base was dominated by married, cisgender and reproductive-age women. Tribal women, migrants, women with disabilities, unmarried women, sexual and gender minorities, women experiencing homelessness and women in institutions were underrepresented. Future studies should examine intersections between gender, caste, class, disability, geography, marital status and access to care. Despite these limitations, the review sheds important insights on social determinants of women's mental health.

CONCLUSION

The evidence synthesis shows that women in India experience a substantial burden of adverse mental health outcomes. Depression, anxiety, common mental disorders, postpartum depression, severe mental disorders, substance use disorders, suicidality, and coping-related concerns were reported across studies. The risk factors are multidimensional and include reproductive transitions, infertility, menopause, comorbid physical conditions, poverty, limited education, widowhood, poor sanitation, domestic violence, intimate partner violence, family dynamics, and low social support. The findings call for a shift from an individual illness model to a life-course, gender-sensitive, family-aware, community-based, and rights-oriented model of mental health care. Women's mental health interventions should move beyond an individual risk model and address the social, economic, relational, legal, and health-system determinants that shape mental wellbeing. Routine psychological screening and counselling should be integrated into reproductive, fertility, antenatal, postpartum, menopausal, and chronic disease care. Community-based prevention, gender-sensitive social and behaviour change communication, family engagement, and

improved referral linkages are necessary to reduce risk and improve access to care. Future research should generate longitudinal evidence, evaluate scalable women-centred interventions, include marginalised groups, and examine how social protection, gender equity, reproductive autonomy, and community-based mental health services can jointly improve women's mental wellbeing in India.

Declaration

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